

8091

CERTIFICATE OF DEATH

08072

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN TB 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital				d. STREET ADDRESS Betterton			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Arthur Middle Howard Last Brice				4. DATE OF DEATH Month 7 Day 25 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/8/86	9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harvey Brice				14. MOTHER'S MAIDEN NAME Bessie Crew			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215 36 1538		17. INFORMANT Address (Wife), Hallie Brice, Betterton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular thrombosis DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 8 days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia due to renal insufficiency due to chronic nephritis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 17 July , 19 60 , to 25 July , 19 60 , that I last saw the deceased alive on 25 July , 19 60 , and that death occurred at 10:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 203 N. Queen Street DATE SIGNED July 26, 60							
ACTUAL SIGNATURE HARRY PAUL ROSS		M.D. 203 N. Queen Street July 26, 60					
PHYSICIAN'S NAME (Type) HARRY PAUL ROSS, M.D.		Chestertown, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-28-60		22c. NAME OF CEMETERY OR CREMATORY STILL POND CEMTNY		22d. LOCATION (City, town, or county) (State) STILL POND, MD	
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy				ADDRESS STILL POND, MD		24a. REC'D BY REGISTRAR DATE JUL 28 '60	
				24b. REGISTRAR'S SIGNATURE Charles E. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8092

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Chestertown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Kent & Queen Anne Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ella Valliant Chapman</u>		4. DATE OF DEATH <u>July 14</u> 19 <u>60</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 21 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>housekeeping</u>	9. AGE (In years last birthday) <u>80</u>
11. BIRTHPLACE (State or foreign country) <u>Church Hill O. A. Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edwin S. Valliant</u>		14. MOTHER'S MAIDEN NAME <u>May T. Faithful</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>James W. Chapman</u>		Address <u>1519 Pentridge Rd Balto 12 Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphatic Leukemia</u> <u>204.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>18 mos.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 20, 1960</u> , to <u>July 17, 1960</u> , that I last saw the deceased alive on <u>7-14</u> , 19 <u>60</u> , and that death occurred at <u>11:27 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chestertown, Md</u> DATE SIGNED <u>7-15-60</u>			
ACTUAL SIGNATURE <u>A.C. Dick</u> M.D.		PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>July 18-60</u>	<u>Chestertown Cemetery</u>	<u>Chestertown Ind.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin J. Williams</u> ADDRESS <u>Chestertown Md</u>		24. REC'D BY REGISTRAR DATE <u>JUL 19 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8093

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent Queen Anne Hospital</u>		d. STREET ADDRESS <u>17X-2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GREGORY Allen Dyes</u>		4. DATE OF DEATH Month Day Year <u>July 20 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1960</u>
9. AGE (In years last birthday) <u>8</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Percy Lee Dyes</u>	
14. MOTHER'S MAIDEN NAME <u>Carolyn Ann Smith</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Carolyn Ann Dyes, Chester, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5 Congenital Adrenal Hyperplasia</u> DUE TO (b) <u>marked Prematurity</u> DUE TO (c) <u>marked Prematurity</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 PK</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 19, 1960</u> to <u>July 20, 1960</u> that I last saw the deceased alive on <u>July 19, 1960</u> , and that death occurred at <u>12:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. R. Bayton</u>		ADDRESS (Street, city or town, state) <u>Centerville Md 21620</u>	
PHYSICIAN'S NAME (Type) <u>C. R. Bayton MD</u>		DATE SIGNED <u>7-20-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jul. 22, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>STEVENSVILLE CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>STEVENSVILLE Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Butler of Butler Bros. Centerville, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	24b. REGISTRAR'S SIGNATURE <u>25 '60</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8094

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b 20 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 103 S. College Ave		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown d. STREET ADDRESS 103 S. College Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sylvester Middle Theodore Last Gable		4. DATE OF DEATH Month July Day 22 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1909
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months 5 Days 10 Hours 15 Min.	11. IF UNDER 24 HRS. Months 5 Days 10 Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver for (L.P. Gas Co		10b. KIND OF BUSINESS OR INDUSTRY Talbot Co. Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Spencer Gable		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 218-16-7617	
17. INFORMANT Mrs. Edw. Collins		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale 527.1 DUE TO Emphysema, obstructive Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) at least 3 1/2 years DUE TO (c) at least 3 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/29 , 19 60 to 7/22 , 19 60 that I last saw the deceased alive on 7/22 , 19 60 , and that death occurred at 5:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED July 23, 1960 ACTUAL SIGNATURE Robert W. Farr M.D. PHYSICIAN'S NAME (Type) Robert W. Farr Chestertown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/25/60	
22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR JUL 26 '60	
24b. REGISTRAR'S SIGNATURE Caroline L. Fennell			

CERTIFICATE OF DEATH

2022

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8099

CERTIFICATE OF DEATH

Reg. Dist. No. 08076

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION at home		d. STREET ADDRESS Edesville	
3. NAME OF DECEASED (Type or print) First Bertha Middle Harris Last Harris		4. DATE OF DEATH Month July Day 22 Year 1960	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1886
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife retired		10b. KIND OF BUSINESS OR INDUSTRY Kent Co. Maryland	
11. BIRTHPLACE (State or foreign country) Kent Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Wickes		14. MOTHER'S MAIDEN NAME Elizabeth Brooks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mary Johnson Address Rock Hall, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/22 , 19 60 , to 7/22 , 19 60 , that I last saw the deceased alive on 7/22 , 19 60 , and that death occurred at 11:45 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE E Kester		ADDRESS (Street, city or town, state) Rock Hall DATE SIGNED 7/22/60	
PHYSICIAN'S NAME (Type) E Kester		E. Kester Rock Hall, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Sharpstown	22b. DATE THEREOF July 25, 1960	22c. NAME OF CEMETERY OR CREMATORY Sharpstown Cem.	22d. LOCATION (City, town, or county) (State) Rock Hall, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Senneth Walby ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR JUL 26 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Hanna

MEDICAL CERTIFICATION

2083

TESTIMONY OF DEATH

11-07-18

(14)

1-1-18

Elizabeth
Hosier

Book

Elizabeth

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8095

CERTIFICATE OF DEATH

Reg. Dist. No. 08077

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rebecca Middle Dulin Last Hepburn				4. DATE OF DEATH Month July Day 10 Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 26, 1874	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10b. KIND OF BUSINESS OR INDUSTRY CHEM. RESEARCH		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Edward Wroth Hepburn				14. MOTHER'S MAIDEN NAME Mary Alice Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Edith Hepburn, Still Pond, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) 10 years ?						INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Comminuted interthrochantic fracture neck of right femur						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Fell while walking		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour 8 a. m. 3-29 19 60 p. m.			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Near home		20f. (City or town) (County) (State) Still Pond Kent Md.			
21. I certify that I attended the deceased from 3-30 , 19 60 , to 7-10 , 19 60 , that I last saw the deceased alive on 7-10 , 19 60 , and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Still Pond, Md. DATE SIGNED 7-10-60							
ACTUAL SIGNATURE A.C. Dick		M.D. Chestertown, Maryland					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-13-60	22c. NAME OF CEMETERY OR CREMATORY I. U. Cemetery		22d. LOCATION (City, town, or county) (State) Worton, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy		ADDRESS Still Pond, Md.		24a. REC'D BY REGISTRAR DATE Jul 12 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8100

CERTIFICATE OF DEATH

08078

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Jenkins Last Jenkins				4. DATE OF DEATH Month July Day 22 Year 1960			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 10, 1871	
9. AGE (In years lost birthday) 88 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Labor		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Unknown			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address Clementine Tilchman, 700 Pine St. Wilm. Del.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke DUE TO 334X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Previous Stroke DUE TO (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 8 hours 18 days 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from June 12, 1960 , to July 23, 1960 , that I last saw the deceased alive on July 23, 1960 , and that death occurred at 8:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE H. H. Hamilton M.D. Millington Md				DATE SIGNED 7/24/60			
PHYSICIAN'S NAME (Type) H.H. Hamilton				Address Millington, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 25, 1960		22c. NAME OF CEMETERY OR CREMATORY Chesterville Cemetery		22d. LOCATION (City, town, or county) (State) Rural Millington Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Millington, Md.				24a. REC'D BY REGISTRAR DATE UL 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Fland	

CERTIFICATE OF DEATH

1918

NAME OF DECEASED John J. Johnson		AGE 45		SEX Male		RACE Colored		RELIGION Catholic		MARRIAGE Married		EDUCATION High School		OCCUPATION Laborer		PLACE OF BIRTH Maryland		DATE OF BIRTH July 10, 1873		DATE OF DEATH July 10, 1918		PLACE OF DEATH Baltimore			
FATHER'S NAME John J. Johnson		MOTHER'S NAME Mary J. Johnson		FATHER'S OCCUPATION Laborer		MOTHER'S OCCUPATION Housewife		FATHER'S PLACE OF BIRTH Maryland		MOTHER'S PLACE OF BIRTH Maryland		FATHER'S DATE OF BIRTH July 10, 1873		MOTHER'S DATE OF BIRTH July 10, 1873		FATHER'S DATE OF DEATH July 10, 1918		MOTHER'S DATE OF DEATH July 10, 1918		FATHER'S PLACE OF DEATH Baltimore		MOTHER'S PLACE OF DEATH Baltimore			
CAUSE OF DEATH Heart Failure		DISEASE Heart Failure		SYMPTOMS Chest pain, shortness of breath		TREATMENT Medicine, rest		DIAGNOSIS Heart Failure		PROGNOSIS Fatal		PATHOLOGICAL FINDINGS Enlarged heart, coronary artery disease		MICROSCOPIC FINDINGS Necrosis of myocardium		TOXICOLOGICAL FINDINGS None		BACTERIOLOGICAL FINDINGS None		HISTOLOGICAL FINDINGS None		RADIOLOGICAL FINDINGS None		OTHER FINDINGS None	
SIGNATURE OF PHYSICIAN J. J. Johnson		SIGNATURE OF WITNESS J. J. Johnson		SIGNATURE OF DECEASED J. J. Johnson		SIGNATURE OF NEXT OF KIN J. J. Johnson		SIGNATURE OF CLERK J. J. Johnson		SIGNATURE OF JURY J. J. Johnson		SIGNATURE OF JUDGE J. J. Johnson		SIGNATURE OF SHERIFF J. J. Johnson		SIGNATURE OF CORONER J. J. Johnson		SIGNATURE OF DISTRICT ATTORNEY J. J. Johnson		SIGNATURE OF COUNTY CLERK J. J. Johnson		SIGNATURE OF CITY CLERK J. J. Johnson		SIGNATURE OF STATE CLERK J. J. Johnson	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8101

CERTIFICATE OF DEATH

Reg. Dist. No. 08079

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Massey				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Massey			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First G. Middle William Last Peacock				4. DATE OF DEATH Month July Day 30 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 5, 1870	9. AGE (In years last birthday) yrs. 89	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph Woodall Peacock				14. MOTHER'S MAIDEN NAME Hannah E. Whittington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Evelyn Bingnear, Massey, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chs. Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) gen. Arteriosclerosis DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 16 years 10 11
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 11, 1960 to July 30, 1960 , that I last saw the deceased alive on July 30, 1960 , and that death occurred at 11:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE H. H. Hamilton				ADDRESS (Street, city or town, state) Millington Md		DATE SIGNED 8/1/60	
PHYSICIAN'S NAME (Type) H. H. HAMILTON							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 2, 1960		22c. NAME OF CEMETERY OR CREMATORY Massey Cemetery		22d. LOCATION (City, town, or county) (State) Massey, Kent Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows				ADDRESS Millington, Md.		24a. REC'D BY REGISTRAR DATE AUG 3 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

8096

CERTIFICATE OF DEATH

Reg. Dist. No.

08080

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Queen Anne's</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crumpton</u> 17X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kentland Memorial</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Baby Girl</u> First <u>Bowell</u> Last		4. DATE OF DEATH <u>July</u> Month <u>31</u> Day <u>1960</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-31-60</u>
9. AGE (In years lost birthday) <u>7</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u>	IF UNDER 24 HRS. Hours <u>15</u> Min. <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James Powell</u>	
14. MOTHER'S MAIDEN NAME <u>Frances Ann Green</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>HOSPITAL RECORDS.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal Distress</u> <u>762.5</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-31</u> , 19 <u>60</u> , to <u>7-31</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7-31</u> , 19 <u>60</u> , and that death occurred at <u>10:15</u> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u> DATE SIGNED <u>7-31-60</u>			
ACTUAL SIGNATURE <u>A.C. Dick</u> M.D.		PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>AUG. 2-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CRUMPTON Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>CRUMPTON, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward S. Melling, M.D.</u> ADDRESS <u>10-X232XVI</u>		24a. REC'D BY REGISTRAR <u>AUG 3 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8097

CERTIFICATE OF DEATH

Reg. Dist. No. 18081

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent and Queen Anne</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sharon</u> Middle <u>Lee</u> Last <u>Rhodes</u>		4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 28-1960</u>
9. AGE (In years last birthday) yrs. <u>2</u> Months <u>7</u> Days <u>47</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>Harry George Rhodes</u>		14. MOTHER'S MAIDEN NAME <u>Sharon Lee Delores Wiggins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>—</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal Atelectasis</u> DUE TO <u>Premature Birth</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 DAY</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State) <u>—</u>
21. I certify that I attended the deceased from <u>6/28</u> , 19 <u>60</u> , to <u>7/2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6/30</u> , 19 <u>60</u> , and that death occurred at <u>3:15</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>—</u>			
ACTUAL SIGNATURE <u>Thomas J. Solon</u> M.D.		PHYSICIAN'S NAME (Type) <u>Thomas J. Solon</u> <u>Chestertown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/2/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Church Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Church Hill Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u> ADDRESS <u>Church Hill</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 11 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrator prior to burial, cremation, or removal, and in any event within 72 hours after death.

2072201XVI

CERTIFICATE OF DEATH

2007

1. NAME OF DECEASED JOHN J. SMITH		2. SEX M		3. AGE 65	
4. DATE OF DEATH 10/15/2007		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH HOME	
7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL		9. PLACE OF BIRTH BALTIMORE, MD	
10. DATE OF BIRTH 10/15/1942		11. SEX M		12. AGE 65	
13. DATE OF DEATH 10/15/2007		14. TIME OF DEATH 10:00 AM		15. PLACE OF DEATH HOME	
16. CAUSE OF DEATH HEART DISEASE		17. MANNER OF DEATH NATURAL		18. PLACE OF BIRTH BALTIMORE, MD	
19. DATE OF BIRTH 10/15/1942		20. SEX M		21. AGE 65	
22. DATE OF DEATH 10/15/2007		23. TIME OF DEATH 10:00 AM		24. PLACE OF DEATH HOME	
25. CAUSE OF DEATH HEART DISEASE		26. MANNER OF DEATH NATURAL		27. PLACE OF BIRTH BALTIMORE, MD	
28. DATE OF BIRTH 10/15/1942		29. SEX M		30. AGE 65	
31. DATE OF DEATH 10/15/2007		32. TIME OF DEATH 10:00 AM		33. PLACE OF DEATH HOME	
34. CAUSE OF DEATH HEART DISEASE		35. MANNER OF DEATH NATURAL		36. PLACE OF BIRTH BALTIMORE, MD	
37. DATE OF BIRTH 10/15/1942		38. SEX M		39. AGE 65	
40. DATE OF DEATH 10/15/2007		41. TIME OF DEATH 10:00 AM		42. PLACE OF DEATH HOME	
43. CAUSE OF DEATH HEART DISEASE		44. MANNER OF DEATH NATURAL		45. PLACE OF BIRTH BALTIMORE, MD	
46. DATE OF BIRTH 10/15/1942		47. SEX M		48. AGE 65	
49. DATE OF DEATH 10/15/2007		50. TIME OF DEATH 10:00 AM		51. PLACE OF DEATH HOME	
52. CAUSE OF DEATH HEART DISEASE		53. MANNER OF DEATH NATURAL		54. PLACE OF BIRTH BALTIMORE, MD	
55. DATE OF BIRTH 10/15/1942		56. SEX M		57. AGE 65	
58. DATE OF DEATH 10/15/2007		59. TIME OF DEATH 10:00 AM		60. PLACE OF DEATH HOME	
61. CAUSE OF DEATH HEART DISEASE		62. MANNER OF DEATH NATURAL		63. PLACE OF BIRTH BALTIMORE, MD	
64. DATE OF BIRTH 10/15/1942		65. SEX M		66. AGE 65	
67. DATE OF DEATH 10/15/2007		68. TIME OF DEATH 10:00 AM		69. PLACE OF DEATH HOME	
70. CAUSE OF DEATH HEART DISEASE		71. MANNER OF DEATH NATURAL		72. PLACE OF BIRTH BALTIMORE, MD	
73. DATE OF BIRTH 10/15/1942		74. SEX M		75. AGE 65	
76. DATE OF DEATH 10/15/2007		77. TIME OF DEATH 10:00 AM		78. PLACE OF DEATH HOME	
79. CAUSE OF DEATH HEART DISEASE		80. MANNER OF DEATH NATURAL		81. PLACE OF BIRTH BALTIMORE, MD	
82. DATE OF BIRTH 10/15/1942		83. SEX M		84. AGE 65	
85. DATE OF DEATH 10/15/2007		86. TIME OF DEATH 10:00 AM		87. PLACE OF DEATH HOME	
88. CAUSE OF DEATH HEART DISEASE		89. MANNER OF DEATH NATURAL		90. PLACE OF BIRTH BALTIMORE, MD	
91. DATE OF BIRTH 10/15/1942		92. SEX M		93. AGE 65	
94. DATE OF DEATH 10/15/2007		95. TIME OF DEATH 10:00 AM		96. PLACE OF DEATH HOME	
97. CAUSE OF DEATH HEART DISEASE		98. MANNER OF DEATH NATURAL		99. PLACE OF BIRTH BALTIMORE, MD	
100. DATE OF BIRTH 10/15/1942		101. SEX M		102. AGE 65	



THIS CERTIFICATE IS VALID FOR THE PURPOSE OF OBTAINING A BURIAL PERMIT IN THE STATE OF MARYLAND. IT IS NOT VALID FOR ANY OTHER PURPOSE.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8098

CERTIFICATE OF DEATH

Reg. Dist. No. 08082

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown,			c. LENGTH OF STAY IN 1b 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg		
d. NAME OF HOSPITAL (If not in hospital, give street address) Kent & Queen Anne's Hospital				d. STREET ADDRESS 2 Faculty Circle		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles First Brendan Middle Shaughnessy Last				4. DATE OF DEATH 7 Month 8 Day 19 Year 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/5/96	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 63		IF UNDER 24 HRS. Days 63		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professor	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professor		10b. KIND OF BUSINESS OR INDUSTRY Education		11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles E. Shaughnessy				14. MOTHER'S MAIDEN NAME Julia Kennedy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220 30 7660		17. INFORMANT Adelaide K. Shaughnessy		2 Faculty Circle Emmitsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of liver. DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of stomach. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-9 1960 to 7-8 1960 that I last saw the deceased alive on 7-8- 1960 and that death occurred at 6:30 p. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE A.C. Dick				ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 7-9-60			
PHYSICIAN'S NAME (Type) A.C. Dick, M.D.				Chestertown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 11, 1960		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wells Wells				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE 12 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8102

CERTIFICATE OF DEATH

Reg. Dist. No.

08083

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesterville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesterville. Rural Millington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Weston Thomas		4. DATE OF DEATH Month Day Year July 10 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 20, 1879
9. AGE (In years last birthday) yrs. 81		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Labor		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Thomas		14. MOTHER'S MAIDEN NAME Elizabeth Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-30-1188	
17. INFORMANT Mrs. Violetta Duckery, Rural Millington, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Sclerosis of the arteries INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours 5 years 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-25 , 19 57 , to 7-10 , 19 60 , that I last saw the deceased alive on 4-1 , 19 60 , and that death occurred at 3 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. G. E. Z. Koralewski		ADDRESS (Street, city or town, state) DATE SIGNED MILLINGTON, MD 7-12-60	
PHYSICIAN'S NAME (Type) DR. G. E. Z. KORALEWSKI			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 14, 1960	22c. NAME OF CEMETERY OR CREMATORY John Wesley Cemetery	22d. LOCATION (City, town, or county) (State) Rural Galena, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows		24a. REC'D BY REGISTRAR 14 '60	
ADDRESS Millington, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8103

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08084

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington		c. LENGTH OF STAY IN 1b 2 years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sara Pollitt Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS none	
3. NAME OF DECEASED (Type or print) Joseph Franklin		First Franklin Middle Trusty Last Trusty		4. DATE OF DEATH July 30, 1960 Month July Day 30 Year 19	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1884	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Various		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Trusty		14. MOTHER'S MAIDEN NAME Tillie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-12-0939		17. INFORMANT Martha Peaker Address Still Pond, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decomposition of the heart - 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension DUE TO (c) obesity					INTERVAL BETWEEN ONSET AND DEATH 2 years 2 2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1957 to July 30, 1960 , that (I) (we) last saw the deceased alive on Jul. 27, 1960 , and that death occurred on July 30, 1960 , from the causes and on the date stated above.					
22a. SIGNATURE Geza Koralewski		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Aug 1, 60	
22c. PHYSICIAN'S NAME (Type) Geza Koralewski		22d. ADDRESS Millington, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/2/60		23c. NAME OF CEMETERY OR CREMATORY Coleman's Cemetery	
23d. LOCATION (City, town, or county) (State) RFD Worton RFD Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walker		ADDRESS Chestetown, Md.		25a. REC'D BY REGISTRAR AUG 2 1960	
25b. REGISTRAR'S SIGNATURE Arthur L. Harris					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8104

CERTIFICATE OF DEATH

08085
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Worton		c. LENGTH OF STAY IN 1b lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home		e. STREET ADDRESS RFD (Bigwoods)	
3. NAME OF DECEASED (Type or print) First Samuel Middle E. Last Washington		4. DATE OF DEATH Month July Day 21 , Year 1960	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 10, 1888
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Lumber Yard		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Washington		14. MOTHER'S MAIDEN NAME Georganna Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW 1 216-09-5209	
17. INFORMANT Mrs. Louise Wallace Worton, Md. RFD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Acute Coronary Insufficiency with Pulmonary Edema 420-1 DUE TO Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 hour several years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 21, 1960 , to July 21, 1960 , that I last saw the deceased alive on July 21, 1960 , and that death occurred at 5:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 7/21/60 ACTUAL SIGNATURE Robert W. Farr M.D. PHYSICIAN'S NAME (Type) Robert W. Farr			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/60	
22c. NAME OF CEMETERY OR CREMATORY Fountain Cem.		22d. LOCATION (City, town, or county) (State) RFD Worton p Kent Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Benneth Waddy		24a. REC'D BY REGISTRAR DATE JUL 25 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

8104

CERTIFICATE OF DEATH

Sex

Male

Age

11 months

Color

White

Dec. 10, 1933

Virginia

Robert Lee Smith

Charles Washington

Georgiana Brown

11-100-200

11-100-200

Coronary Arteriosclerosis
Pulmonary Edema
Acute Coronary Insufficiency with

four
several
years

July 21

July 21

July 21

2:00

60

Chesapeake, Md.

Robert E. Smith

Chesapeake, Md.

Chesapeake, Md.

Chesapeake, Md.